

Executive Order 55

Updated Interim Report Governor's Health Information Technology Council



October 1, 2007



COMMONWEALTH OF VIRGINIA

OFFICE OF THE GOVERNOR

Executive Order 55

CONTINUING THE HEALTH INFORMATION TECHNOLOGY COUNCIL

Importance of the Issue

Building and improving our health information technology infrastructure is critical to providing quality health care. As the complexity of our health care system continues to grow, health care providers must leverage information technology to improve patient safety and health outcomes. It is critical that Virginia health care providers employ health information technology to provide the best care for patients. Improving health care technology infrastructure offers the potential for both improving the quality and safety of patient care and helping control costs.

Health care information technology is important in both institutional and non-institutional settings. It is important for the Commonwealth to encourage the development of appropriate, interoperable health care information technology to improve the quality of care and help control costs. As was recognized in the 2006 Appropriation Act, at the request of my administration, an appropriate first step is to convene major stakeholders and leading thinkers on this issue.

Establishing the Council

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to Section 2.2.-134 of the Code of Virginia, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the Governor's Health Information Technology Council.

In addition to the responsibilities identified in the 2006 Appropriation Act, the Council shall have the following responsibilities:

1. Encourage public-private partnerships to increase adoption of electronic medical records for physicians in the Commonwealth.
2. Identify areas where health information technology can lower health care costs for the Commonwealth of Virginia as an employer and health insurer.
3. Provide a final report to the Governor by May 15, 2008 outlining the activity of the Council, providing an overview of state level Health IT activity in the Commonwealth, and making any recommendations the Council should desire to improve the state of Health IT adoption in the Commonwealth.
4. Recommend budget proposals necessary to advance the Health IT agenda including encouraging long-term, sustained adoption and interoperability of health information technology in the Commonwealth in the report to the Governor by May 15, 2008.
5. Periodically review and comment on the Commonwealth's Health IT strategy including initiatives not under the direct purview of the Health IT Council.
6. Examine other issues as may seem appropriate.

The Council shall consist of the members previously appointed by the Governor and to serve at his pleasure, in accordance with the parameters laid out in the 2006 Appropriation Act. Additional members may be appointed at the Governor's discretion. The Secretaries of Health and Human Resources and Technology will co-chair the Council and will be responsible for convening the Council.

The Council shall meet at the call of the co-chairs to oversee the development of the health information technology infrastructure in the Commonwealth. Members of the Council shall serve without compensation. They may receive reimbursement for expenses incurred in the discharge of their official duties.

Staff support shall be provided through the Office of the Governor, the Secretaries of Technology and Health and Human Resources, and such other agencies as the Governor may designate. It is my intention to create a cross-secretarial team to provide staff support to this effort. It is also my intention to draw whenever possible on private sector expertise. Direct expenses for this effort, exclusive of staff time, are estimated at \$9,000.

This Executive Order shall become effective upon its signing and shall return in full force and effect until July 1, 2008, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this
10th day of September, 2007.

Timothy M. Kaine, Governor

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Health IT Council Membership

Co-Chairs

The Honorable Marilyn Tavenner, Secretary of Health and Human Resources

The Honorable Aneesh Chopra, Secretary of Technology

Members

Barbara Baldwin of Richmond, chief information officer for the University of Virginia Health Systems;

Golden H. Bethune of Hampton, executive vice-president and administrator of Riverside Regional Medical Center;

Elizabeth T. Brown of Virginia Beach, director of information for technology and long term care and home care services at Sentara Healthcare;

Nancy Davenport-Ennis of Yorktown, chief executive officer of the Patient Advocate Foundation;

Ronald DeCesare, Jr. of Annandale, chief executive officer of Professional Healthcare Resources;

Dr. Don E. Detmer of Crozet, chief executive officer and president of the American Medical Informatics Association;

The Honorable Janet D. Howell of Reston, member of the Senate of Virginia;

Dr. Gopinath Jadhav of Richmond, physician for Southside Gastroenterology;

Bob Johnson of Potomac, Maryland, senior vice-president of Consumer Sales at Sprint Nextel;

David Merritt of Alexandria, project director for the Center for Health Transformation;

Gil Minor, III of Richmond, chairman and chief executive officer for Owens and Minor;

Balan Nair of McLean, chief information officer and executive vice-president of technology operations at AOL;

Dr. Keith H. Newby, Sr. of Norfolk, physician at Cardiology and Arrhythmia Consultants, Inc.;

The Honorable Samuel A. Nixon, Jr. of Richmond, member of the Virginia House of Delegates;

The Honorable John M. O'Bannon, III of Richmond, member of the Virginia House of Delegates;

Megan Philpotts Padden of Norfolk, vice-president of government programs and e-business at Sentara Health Plans;

Joseph Roach of Martinsville, chief executive officer of Memorial Hospital;

Chas W. Roades, Jr. of Vienna, executive director of research for the Advisory Board Co.;

Richard D. Shinn of Midlothian, director of public affairs for the Virginia Primary Care Association;

Anna Slomovic of Arlington, chief privacy officer at Revolution Health Group;

Larry T. Wilson of Gate City, physician at Holston Medical Group;

Michele M. Vilaret of Alexandria, director of telecommunication standards for the National Association of Chain Drug Stores.

Staff Acknowledgements

Kim Barnes, Policy Analyst, Virginia Department of Health

Heidi Dix, Assistant Secretary of Health and Human Resources

Thomas Gates, Assistant Secretary of Technology

Betty Jolly, Policy Education Director, Department of Health Professions

Aryana Khalid, Assistant Secretary of Health and Human Resources

Greg Walton, Executive Advisor to the Health IT Council

Executive Summary

In August of 2006, the Health IT Council membership began the work of identifying and encouraging long-term sustained adoption and interoperability of health information technology. Governor Timothy M. Kaine in Executive Order 29 established the Health Information Technology Council and charged that body with recommending the most innovative and effective investments for the \$1.5 million appropriated by the 2006 General Assembly to encourage the adoption of electronic health records throughout the Commonwealth and in compliance with federal standards.

The Council was continuing the work of the 2005 Governor's Task force on Information Technology in Health Care, which had examined the state of readiness in the Commonwealth for electronic standardized health information. The Task Force found excellent progress within hospital and health systems; health plans committed to increased use of electronic health records; nursing facilities just beginning to undertake efforts to implement information technology resources; and safety net providers operating a practice management system purchased from one vendor. Barriers to the overall state adoption rate were seen most clearly in the office of the physician, particularly the small office. (Given that physicians in small practices account for 88 percent of all outpatient visits and four-fifths of physicians work in small practices, this group represents a sizable adoption gap.) In the final analysis, electronic health information adoption in Virginia was underway. However, each effort was independent and proceeding at its own pace. The Task force recommended a budget for 2006 to promote the adoption of best provider practices, a master patient index and a continuation of executive appointees to further electronic health records adoption.

Executive Order 29 directs technology infrastructure as critical in order to improve patient safety and health outcomes. The statutory mandate in the 2006 Appropriations Act (Item 293) of \$500,000 in the first year of the biennium and \$800,000 in the second year directs funding to partner the state with providers and businesses toward interoperability. General Assembly's budget language created a mechanism for distributing the \$1.3 million in funding designated for "encouraging the adoption of electronic health records throughout the Commonwealth."

The Council took the work of 2005 and the fast lane approach and set out to provide an unbiased approach for determining providers and business partners mature enough to have the potential to jumpstart adoption in the Commonwealth. To determine readiness to implement, Council issued a request for information (RFI) on August 21, 2006, announcing its intention to seek Statements of Interest (SOI) from private entities and public-private partnership. On August 31st, an information conference was held for

interested parties, with the Statements of Interest due Friday, September 15, 2006. Sixty-one (61) proposals were submitted. The Council eliminated the proposals that were not action ready (studies) and completed its evaluation of the 56 remaining proposals by October 15th based on a probability index that drew the pool down to 34 proposals. Of the thirty-four (34) remaining a letter rank of A, B, or C was awarded. This probability of success exercise, or risk map, brought the proposals earning a high enough “grade” to be considered an “A” down to 15. Three of the four subcommittees were charged with an evaluation of the remaining proposals based on the authority specific to their field: business, physician, and privacy/security. The Business Case subcommittee graded the 15 proposals that were ranked as an “A” and handed off their ratings of business viability with scores from 100 to 0 to the Physician Communication and Privacy/Security subcommittees. These two subcommittees reviewed the proposals that had ranked above 80 on the 100 point scale.

The fourth subcommittee, the Ranking Committee, then developed a weighted grid system to combine the input of the 3 other subcommittees. The proposals were ranked according to business case score and then awarded points based on the previous rankings of the Physician Committee and the Privacy Committee. Finally these scores were weighted as 70% for Business and 15% each for Privacy and Physician.

The Submission Collection Tool used in the RFI and in the probability index used in each committee identified objectively those partners whose businesses/practices were already mature in the field of changing medical technology and changing physician/health delivery cultures. In addition, the collection tool looked for a culture of action-orientation from its potential partners as well as a teaching-orientation. (projects able to be replicated across practices and the state.) Teaching-orientation is an important piece, not just for Virginia, but from the point of view of national leadership in the electronic health record field. “To be connected” Michael O. Leavitt, Secretary Health and Human Services, has repeatedly called the first step to true transparency in health care.

Finally, project proposals were judged on their ability to (1) drive adoption of ambulatory health records in the Commonwealth, (2) improve interoperability of medical records, and (3) leverage the Commonwealth’s role as a large purchaser of healthcare to lower costs.

Friday December 1, 2006, the Health IT Council made its recommendation to the Governor for how the \$500,000 in funding designated by the General Assembly for this year should be spent. The Council gave the green light to 3 projects while making a point to praise many of the projects that didn’t receive funding. The Council felt that due to the relatively small amount of funding available this year it was better to concentrate it in a

few projects to maximize the possibility of success. The Council recommended that the Virginia Department of Health negotiate with the top three rated proposals ([MedVirginia](#), [Community Care Network of Virginia](#), and [CareSpark](#)) to determine if there is flexibility in their requests. The goal is to fund as many projects as possible without endangering the likelihood of their success. On February 28th, Governor Kaine announced that each project would receive \$250,000 in funding.

The electronic health record has the capacity to improve the quality of life in ways that previous generations could not even imagine. This is a beginning. Next steps for this Council will be organizing procurement for the master patient index, directing money to Health IT funding priorities; identifying appropriate support for proposals of superior merit that fiscal restraints eliminated from funding consideration; developing an approved but not funded list; finding market-led ways to bring better health care to patients at lower cost and with less hassle; and other duties as identified by the Chairs.

This report begins with a brief introduction followed by chapters relating to the findings of the Council recommendations. It concludes with a brief discussion of \$250,000 set aside by the General Assembly for “a pilot project developing a Master Patient Index.”

Background

Synopsis of 2005 EHR Task Force

In April 2005 Governor Mark Warner issued Executive Directive 6 (ED 6) creating the Governor's Task Force on Information Technology in Health Care charged with conducting a one-year study to advise the Governor and the General Assembly on the current status of Virginia's proliferation of electronic health records. The goal stated in ED 6, in addition to determining the state readiness benchmark, included a next step of advising how to get information about patients out of paper files and into electronic databases that can connect to one another so that any doctor in Virginia can access all the information needed to help any patient at any time and in any place.

The Electronic Health Record (EHR) was identified as a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information would be patient demographics, progress notes, problem lists, vital signs, past medical history, review of systems, immunizations, laboratory data, radiology reports, and other components of medical records. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Four subcommittees were formed to map the state of adoption of electronic health records in Virginia. Subcommittee 1 surveyed where EHR is in Virginia today and identified current best practices from Virginia and other states, including funding; Subcommittee 2 surveyed EHR in private medical practices; Subcommittee 3 surveyed and analyzed the current state of EHR in hospitals and institutions; and Subcommittee 4 explored EHR Interoperability, governance, policy and legal issues.

The Task Force Subcommittees found rapid progress within hospital and health systems in terms of EHR adoptions, even relative to other states. Information technologies are already the norm in non-clinical areas of hospitals and quickly becoming the norm for clinical areas as well. In addition, health plans surveyed evidenced a broad understanding and commitment to the value of wider health care IT development. In general, health plans are committed to a system that can assure greater patient safety, improved quality and increased efficiency through the increased use of electronic health records. There is a broad understanding by health plans of the benefits and value of broader health care IT development. For example, integrated delivery system-model health plans (e.g., Kaiser and Sentara) are utilizing sophisticated information management systems that will enhance the quality of patient care. Adoption in Virginia's nursing facilities, like their counterparts around the country, are just now beginning to seriously undertake efforts to implement information technology resources beyond those associated with basic financial management. Information provided by responses from VHCA members representing nearly 50% of all Virginia nursing facility beds indicates significant IT implementation activities in a number of clinical areas including care planning, MDS assessment and submission, dietary management, quality assurance and

therapy management. Less than 15% of Virginia nursing facilities are actively using, implementing or testing EHR resources and applications. Safety net providers or Federally Qualified Community Health Center organizations in Virginia (who serve the uninsured and underserved populations throughout the state in eighty-eight (88) urban and rural sites) coordinated their information technology efforts to establish a statewide network and operate a practice management system purchased from one vendor.

Barriers to the overall state adoption rate were seen most clearly in the office of the physician, particularly the small office. This suggested a need for greater support for practices, particularly smaller ones, in this quest if the benefits expected from EHRs are to be realized. Given that physicians in small practices account for 88 percent of all outpatient visits and four-fifths of physicians work in small practices, this group represents a sizable adoption gap.

In brief, some of the work needed to implement electronic health information adoption in Virginia was found to be underway. However, each effort was independent and proceeding at its own pace. There was found to be limited progress made toward ensuring the interoperability of any systems across sectors and regions.

Based on its findings of disparate quality and innovation from system to system and region to region and provider to provider and the gap of interoperability across all sectors and regions, the Task Force offered five recommendations:

Recommendation # 1: Establish an ongoing statewide electronic health care group or council to construct financial models and a probability index to determine best practice projects to be funded or supported by the Commonwealth.

Recommendation # 2: In the state's role as a purchaser, work closely with the Departments of Human Resource Management and Medical Assistance Services to establish incentives for EHR adoption

Recommendation # 3: Appropriate state monies to facilitate increased eHealth initiatives.

Recommendation #4: Identify and support the implementation of a master patient index, (MPI) system that facilitates the secure and accurate linkage of patient medical information that resides in different systems for patients and authorized users.

Recommendation #5: Provide a separate and coordinate alliance to concentrate on the health information workforce requirements.

Task Force members were unanimous in their view that states serve a valuable role as laboratories for national solutions and that the Commonwealth could achieve the vision of pervasive, real time, electronic health records through a journey of several years which will require significant degrees of collaboration across providers, health plans and public

sectors. The strategy behind these recommendations is to connect all providers in the Commonwealth. The report was submitted to Governor Warner on November 1, 2005.

Granting Process

A request for information (RFI) was issued on August 21, 2006, announcing the Governor's Health Information Technology Council intention to seek Statements of Interest (SOI) from private entities and public-private partnerships qualified and experienced with electronic health records (EHR) implementation. Project proposals were judged on their ability to:

1. drive adoption of ambulatory health records in the Commonwealth;
2. improve interoperability of medical records; and
3. leverage the Commonwealth's role as a large purchaser of healthcare to lower costs.

The RFI was an outgrowth of Governor Kaine's Executive Order 29 of July 20, 2006, which formed the Council for Health Information Technology and implemented the General Assembly's budget language to create a mechanism for distributing the \$1.3 million in funding designated for "encouraging the adoption of electronic health records throughout the Commonwealth."

The Office of Health Information Technology received 61 proposals for evaluation by the Governor's Health IT Council. These proposals were submitted by a geographically diverse group of partners representing a broad spectrum of information technology applications. Proposals can be grouped by project outcome into three broad categories based on the RFI criteria they were focused on. These include those proposals that extend electronic health record adoption, those that seek to improve quality and reduce costs and those that seek to exchange information and improve interoperability. Fifty-seven percent of the proposals dealt with the issue of data exchange and the mechanisms needed to improve interoperability. Thirty percent of the proposals were mechanisms to extend electronic health record adoption and thirteen percent of the proposals represented IT solutions to improve quality and reduce costs.

After an initial understanding of all proposals, the Governor's Health IT Council adopted a gated review process to be used in determining the applicants' merit for grant funding. The first review was conducted to ascertain the strength and potential of the proposal's business case and of the partnership's potential ability to deliver upon its vision. The second review was conducted to judge the potential of the proposal to involve and assist the physician community in providing quality, cost-effective healthcare to the citizens of the Commonwealth. The third review was conducted to ascertain the ability of the proposal to protect the privacy and security of personal health information. The final review was conducted to prioritize the proposals based upon the recommendations of the previous reviews. A detailed explanation of the review process can be found in the subsequent sections of this report.

Section I – Business Case Subcommittee

The Health IT Council received an impressive number of responses considering the short time that applicants had to respond. To get this number down to a manageable size for the Business Case Subcommittee to review, the Chairman asked staff to take a first pass in reviewing the proposals. This first pass looked to identify proposals that were purely for studies, did not contain a provider partner, or for some other reason were not actionable. After this initial pass thirty-four proposals remained.

At the request of the Business Case Subcommittee Chair, the Council's Executive Advisor also provided a letter rank of A, B, or C to the remaining proposals to help triage the work of the Council. This letter ranking was based on the Executive Advisor's vast experience and knowledge based with electronic health records as well as what he considered to be good proposals for the Commonwealth.

After reviewing the Executive Advisor's grades, the Business Case Subcommittee graded the 15 proposals that were ranked as an A. Each member of the Subcommittee was give two to three proposals to review. In order to grade the proposals, the Business Case Subcommittee developed an evaluation mechanism based on the following four criteria areas:

- Financing and Readiness - 30% of total score
- Impact - 30% of total score
- Technology and Scalability - 30% of total score
- Geography and Stakeholder Diversity - 10% of total score

The following table shows the evaluation method used by the Business Case Subcommittee to determine the ranking of the various proposals. The evaluation mechanism was quite detailed so that the Subcommittee would be looking at the proposals from a variety of angles. The Business Case Subcommittee developed the evaluation mechanism through internal review and suggestions/modifications from the Health IT Council.

Evaluation of Grant Applications
Business Case Subcommittee

<u>Applicant:</u>					
<u>Reviewed by:</u>					
<p><u>Instructions:</u> Please use this form to evaluate and score each application assigned to you, each of which was ranked as an A by Greg Walton, executive advisor to the council. You are encouraged to use this form to score the applications that were ranked as a B and C by Mr. Walton. If you choose not to use this form to evaluate those applications, please use your own criteria at your discretion. For each item identified below, circle the number to the right that best fits your judgment of its quality. Please return your submissions to David Merritt, subcommittee chair, by October 25, to dmerritt@gingrichgroup.com.</p>					
<i>Financing and Readiness (30% of total score)</i>	Po or				Exc elle nt
Funding will start, maintain, or complete the proposal <i>(1 for new project; 5 for completion of project)</i>	1	2	3	4	5
Financial sustainability of the proposal	1	2	3	4	5
Financial viability of applicant and partners	1	2	3	4	5
State of readiness of the applicant and partners	1	2	3	4	5
Applicant influence over partners and process	1	2	3	4	5
Financial commitment of partnering organizations	1	2	3	4	5
Add the numbers above for section total					
Impact (30% of total score)					
Proposal would bring value to the participating citizens	1	2	3	4	5
Proposal would bring value to the region	1	2	3	4	5
Proposal would bring value to the Commonwealth of Virginia	1	2	3	4	5
Supports the Governor's health care priorities by <u>(please add the number of yes answers to get question total)</u> :	1	2	3	4	5
Reducing nursing/healthcare staffing shortages	Yes (1)			No (0)	

Evaluation of Grant Applications
Business Case Subcommittee

Expanding access to care (Medicaid, SCHIP, the uninsured)	Yes (1)			No (0)	
Improving long-term care, home care, and/or care for the aging	Yes (1)			No (0)	
Improving patient safety	Yes (1)			No (0)	
Promoting wellness and prevention	Yes (1)			No (0)	
Supports federal health IT initiatives as outlined by HHS	1	2	3	4	5
Promotes the continuity of care rather than episodic care	1	2	3	4	5
Add the numbers above for section total					
Technology and Scalability (30% of total score)					
Viability of the technology	1	2	3	4	5
Scalability of the technology, both internally and externally	1	2	3	4	5
Experience in the field (i.e., is this an untested technology?)	1	2	3	4	5
Ease-of-use, training and need for continuing education for users	1	2	3	4	5
Increases the adoption of health IT	1	2	3	4	5
Promotes interoperability	1	2	3	4	5
Add the numbers above for section total					
Geography and Stakeholder Diversity (10% of total score)					
Depth of partnerships among health care stakeholders	1	2	3	4	5
Geographic environment for actual proposal					
Rural	Yes (1)			No (0)	
Urban	Yes (1)			No (0)	
Technology <i>can be</i> deployed in both rural and urban environments	1	2	3	4	5
Add the numbers above for section total					
Overall Total					

Top scores were given to the following five proposals:

- MedVirginia with a score of 91;
- Community Care Network of Virginia with a score of 89;
- Valley Health with a score of 81;
- Care Spark with a score of 81; and
- Inova Health-Erickson Retirement Communities with a score of 80;

Once the Business Case Subcommittee completed its evaluations, the Physician and Privacy Subcommittees reviewed the proposals that ranked above 80 on the 100-point scale developed by the Business Case subcommittee. This resulted in a total of five proposals being reviewed.

The Council members serving on the Business Case Subcommittee are as follows:

Chair: David Merritt

Members: Bob Johnson; Barbara Baldwin; Gil Minor; The Honorable Sam Nixon; Don Detmer, M.D.; Richard Shinn; Balan Nair

Staff: Heidi Dix and Aryana Khalid

Section II – Physician Subcommittee

The Request for Information process, outlined earlier in this document, sought Statements of Interest around the themes of increasing physician adoption of Electronic Health Records, software interoperability and leveraging the role of the Commonwealth to lower cost and raise quality using information technology. Each of these themes impacts the practice of medicine. The need to have strong ongoing communications with approximately 33 thousand physicians licensed to practice in Virginia is an ongoing critical success factor for all projects.

This subcommittee gathered input about electronic Health Record issues and opportunities around the Commonwealth as well as guided the ongoing efforts to communicate with physicians active in pilot projects, physician associations and other groups of physicians around the state. Meetings were held with the Medical Society of Virginia as well as the Virginia Hospital and Healthcare Association to determine ranking of RFIs from associations.

Following the ranking by the Business Committee of numerical scores for grants meeting the criteria of the RFI, the Physician Subcommittee took the top scorers (grade of 80 and above) and ranked those applicants based on three criteria: Implementation: Ease of Adoption (40% of total score); Interoperability: (40% of total score); and Smaller Practice Subsidies (20% of total score). Top scores were given to MedVirginia, Community Care and Valley Health.

The Council members serving on the Physician Communication Subcommittee are as follows:

Chair: Larry Wilson, M.D.

Members: Keith Newby, M.D.; Delegate John O'Bannon, M.D., 73rd District of Virginia; Julie Christopher, Commissioner of Aging; Ronald DeCesare, Jr., chief executive officer of Professional Healthcare Resources; Patrick Finnerty, Director of Medical Assistant Services; Mary Habel, Health Benefits program, Department of Human Resources; Gopinath Jadhav, M.D.; James Reinhard, MD. Commissioner Mental Health, Mental Retardation, and Substance Abuse Department

Staff: Betty Jolly, Policy Education Director, Department of Health Professions

Evaluation of Grant Applications
Physician Communication Subcommittee

Applicant:

Reviewed by:

Instructions: Please use this form to evaluate and score each application assigned a merit number of 80 or above by the Business Case Subcommittee. You are also encouraged to use this form to score any applications that you wish to evaluate. This subcommittee is bound by two basic questions: (1) what proposals can earn physician loyalty, coming closest to being designed with physician intent to treat patients effectively and maximize their use of time (in addition to being designed to support the business of the medical practice and proposals, which is the ranking provided by the Business Case Subcommittee); and, (2) what proposals hold the best potential for a “federated model” that could be shared or co-oped by authorized access and according to formalized business agreements, probably to include peer-to-peer requests. If you choose not to use this form to evaluate applications, please use your own criteria at your discretion or you may choose to give an overall total score for each of the three divisions rather than discrete questions provided. For each item identified below, put a check in the characterization to the right that best fits your judgment of its quality. Please return your submissions to Larry Wilson, M.D., subcommittee chair, by November 15 to ltw@hmgkpt.com or Betty Jolly, staff, betty.jolly@dhp.virginia.gov who will compile and forward.

<i>Implementation: Ease of Adoption</i> <i>(40% of total score)</i>	Low	Medium			High
Proposal functionalities in achieving secure electronic communication with patients					
Proposal functionalities in achieving computerized physician order entry					
Proposal functionalities in achieving electronic viewing of patients’ test results					
Proposal functionalities in achieving e-prescribing					
Proposal functionalities in achieving electronic eligibility verification and claims submission;					
Overall appeal to physicians in order to capture their utilization, loyalty and reliance on it as a vehicle for improved patient care					
Ability to service and train					
Add the numbers above for section					

Evaluation of Grant Applications Physician Communication Subcommittee					
total					
Interoperability: (40% of total score)					
Cross-enterprise document exchange has commonalities present to transfer clinical practice from site to site					
Cross-domain patient identification management					
Technical support planning: methods for contacting, hours of operation, requests for enhancements and customizations					
Ability to targeting the smaller practice (one to 15 providers)					
Ability to target the medium-sized providers (10-99 providers)					
Ability to target the large practices (greater than 100 providers)					
Systems conforms to an industry-wide framework for implementing standards					
Promotes optimal patient care.					
Add the numbers above for section total					
Smaller Practice Subsidies (20% of total score)					
Potential to include small practices in large electronic networks; for example proposal has potential to share both technology overhead and human resources, and might choose a centralized database or shared utility approach to house data and make it available to smaller providers as well as large providers.					
Add the numbers above for section total					
Overall Total					

Section III – Privacy Subcommittee

As Virginia automates patient records it is the intent of the Commonwealth to fully protect the privacy of patient health information. First, this means compliance with all Federal and Virginia laws. Secondly, defining proactive measures to continually raise the public confidence and trust in the Commonwealth's actions insuring patient privacy.

The Privacy and Security Subcommittee conducted a proposal review with a keen focus on the protection of the patient. In addition, the Subcommittee issued general principles on this subject to act as guidance for the public's review of health IT options. Below is a listing of these principles.

After the Business Case Committee scored the proposals for the quality of the business case, the Privacy and Security Committee reviewed the top scorers (grade of 80 and above) on whether these proposals complied with privacy protection principles. In most cases, the information provided in the proposals was not sufficient for a detailed evaluation, so the Committee decided to vote "yes" or "no" based on the general information in the proposals. MedVirginia, CareSpark and Inova and Erickson proposals were ranked as yes, Community Health Centers ranked as no and the members were undecided concerning Valley Health.

General privacy principles for Virginia Health IT

Principle I: **Openness and Transparency**

There should be a general policy of openness with respect to personal data. Individuals should be able to know what information exists about them, the purpose of its use, who can access and use it, and where it resides.

Principle II: **Purpose Specification and Minimization**

The purposes for which personal data are collected should be specified at the time of collection, and the subsequent use should be limited to those purposes, related purposes, or ones that have been specified at the time of change of purpose.

Principle III: **Collection Limitation**

Personal health information should only be collected for specified purposes, should be obtained by lawful and fair means, and where possible, with the knowledge and consent of the individual.

Principle IV: **Individual Participation and Control**

Individuals should control access to their personal information. Individuals should have the right to:

- Have personal data relating to them communicated within a reasonable time (at an affordable charge, if any), and in a form that is readily understandable
- Be given reasons if a request is denied and to be able to challenge such a denial
- Challenge data relating to them and have it rectified, completed, or amended

Principle V: Data Integrity and Quality

All personal data collected should be relevant to the purposes for which they are to be used and should be accurate, complete and current.

Principle VI: Security Safeguards and Controls

Reasonable security safeguards against such risks as loss or unauthorized access, destruction, use, modification, or disclosure should protect person

Principle VII: Accountability and Oversight

Entities in control of personal health data must be held accountable for implementing these information practices.

The Council members serving on the Privacy Subcommittee are as follows:

Chair: Anna Slomovic

Members: Golden Bethune, Nancy Davenport-Ennis, The Honorable Janet Howell, Michele Vilaret

Staff: Kim Barnes, Policy Analyst, Virginia Department of Health

Review Criteria
<p>Evaluation questions: Principle I</p> <ol style="list-style-type: none"> 1. What information will be made available to individuals about the program in this grant?
<p>Evaluation questions: Principle II</p> <ol style="list-style-type: none"> 1. Does this grant use information originally collected for another purpose? If so, how is the purpose of original collection related to the purpose for which data will be used under this grant? 2. If new information is collected during the grant, what mechanism is in place to ensure that the terms on which the information is collected during the grant are integrated into future uses and disclosures of the data? 3. Will personal information be shared? If so, with which organization(s) and for what purpose(s)? 4. Does the grant involve data analysis to identify previously unknown patterns, individuals or concerns? (Sometimes this is referred to as data mining) If so, what are the purposes of these analyses? 5. Are policies and procedures in place to review requests for alternative data use? 6. Are proper processes in place for data deidentification?
<p>Evaluation questions: Principle III</p> <ol style="list-style-type: none"> 1. What notice is provided to the individual before the information is collected, used or disclosed? 2. Do individuals have the right to consent to or refuse to participate? 3. Do individuals have a right to designate what particular types of information they want shared? For example, can HIV test results be withheld from being shared? 4. What are the sources of personal information? (Individual, EHR system, automatically collected by servers, pulled from some existing data store, etc.) 5. Why is each type of information necessary? 6. How were data integrity, privacy and security analyzed as part of the technology selection process? What design choices were made to enhance privacy?
<p>Evaluation questions: Principle IV</p> <ol style="list-style-type: none"> 1. What are the procedures that allow individuals to gain access to their own information used under this grant? 2. What are the procedures for correcting inaccurate or erroneous information?

Section IV – Ranking Subcommittee

The Ranking Subcommittee met immediately following the November 17th meeting of the full Council to determine their process. The subcommittee acted on the premise that their role was to provide a structure to balance the work of the previous three subcommittees and not to re-do their work by considering business case, physician, or privacy concerns again. The subcommittee also decided to rank only projects that had been graded by all three of the other subcommittees and therefore only ranked the 5 projects that had scored above an 80 on the business case ranking.

The subcommittee decided to assign both numerical scores and percentage weights to the work of the previous committees. First the business case scores were converted into 1st through 5th place with point totals starting at 25 for 1st place and descending in 5 point increments to 5 pts for 5th. Because of a tie for 3rd place each project was awarded 12.5 pts. The Privacy subcommittees work was then awarded 5 pts for approval and 0 pts for no approval. The Physician subcommittees work was translated into 5 pts for a “Low” score, 10 pts for a “Medium” score, and 15 pts for a “High” score. Finally, business case was weighted at 70% and Physician and Privacy at 15% each. The following table resulted:

Project	Business (70%)	Privacy (15%)	Physician (15%)	Ranking Score
MedVirginia	25	5	15	20.5
Community Care Network	20	0	15	16.25
Valley Health	12.5	0	15	11
CareSpark	12.5	5	5	10.25
Erickson	5	5	10	5.75

The subcommittee then forwarded this chart as its recommendation to the entire Council for its review during the December meeting.

The Council members serving on the Privacy Subcommittee are as follows:

Chair: Chas Roades

Members: Joe Roach, The Honorable Aneesh Chopra, The Honorable Marilyn Tavenner, Megan Philpotts Padden, Jim Burns, M.D.

Staff: Thomas Gates, Assistant Secretary of Technology

Recommendations

Alteration of Ranking Weights

At its December 1, 2006 meeting, the Full Council met to review the work of the Ranking Committee and make proposals. Some members objected to the ranking committee's choice of point totals. They believed that the awarding of only 5 points for a proposal that met the Privacy Subcommittee's standards while giving 15 points to a proposal that scored a "high" from the Physician committee undervalued the impact privacy should have on the Council's recommendation. By consensus the Council changed the point total from 5 to 15 for a project approved by the Privacy Subcommittee. The change reordered the chart approved by the Ranking Subcommittee by switching CareSpark and Valley Health. And the following order was adopted:

Project	Business (70%)	Privacy (15%)	Physician (15%)	Ranking Score
MedVirginia	25	15	15	22
Community Care Network	20	0	15	16.25
CareSpark	12.5	15	5	11.75
Valley Health	12.5	0	15	11
Erickson	5	15	10	7.25

Total Cost for Ranked Projects

Project	Ranking Score	Cost
MedVirginia	22	\$248,000
Community Care Network	16.25	\$335,000
CareSpark	11.75	\$390,000
Valley Health	11	\$300,000
Erickson	7.25	\$274,500
Total	-	\$1,547,500

Recommendation for Funding

The Council decided to only allocate the FY07 funding totally \$500,000. Because the total cost of the ranked projects exceeds the funds available by a large margin a discussion took place on the merits of partial funding. The Council wanted to avoid spreading money around so much that projects would be compromised. However, a consensus emerged that partial funding was a good alternative if the grantees still believed they could produce value with less money. The Council, therefore, recommended that the Department of Health and the Co-Chairs negotiate with the top three ranked projects to see if their projects could be fit within the \$500,000 available.

Next Steps

The Council will meet again in late 2007 to discuss a broader scope for the Council in line with the new executive order. Governor Kaine has also recommended as part of his response to the budget deficit a reduction by half of the remaining funds leaving \$300,000 for the next round of grants.

Updates

First Round Grants Awarded

On February 28, 2007 Governor Kaine announced that MedVirginia, the Community Care Network of Virginia, and CareSpark all agreed to accept \$250,000* and that some FY08 funds had been moved forward to this fiscal year to accomplish the third award.

Updates from First Round Grant Recipients

These organizations participate in monthly conference calls in which they report progress, share implementation strategies, and support each other's progress through collaborations. Through the process of sharing experiences and expertise, the original grant monies are being leveraged throughout the recipients to produce even greater project outcomes for the citizens of Virginia. For example, the Department of Medical Department of Mental Health Mental Retardation and Substance Abuse Services is participating in the conference calls now to study the implementation of an EHR system within a CSB in Martinsville. This specially modified EHR for behavioral health issues could then be used in other areas of the state avoiding costly design time. The state behavioral health provider in far southwest Virginia is interested in this development for its future participation with CareSpark.

In addition, both CareSpark and MedVirginia submitted successful proposals for the Nationwide Health Information Network Trial Implementation (NHIN II) funding. Both organizations received monies during the NHIN I period. In their current proposals, each organization has submitted letters of support and committed to interoperability testing. This clearly has strengthened their proposals and demonstrated the strength of Virginia's infrastructure in Health IT. These two organizations will also be collaborating on project access issues to help facilitate medical service delivery by the safety net providers in their areas.

Community Care Network of Virginia

The Community Care Network of Virginia is developing a Community Care Record in conjunction with Piedmont Community Services Board, Piedmont Access to health Services, the Pittsylvania County Community Action and eClinical Works (eCW) to

* MedVirginia will receive only \$248,000 – their total request.

electronically share patient information between providers of care and services. Over the past several months, the workgroup with representatives from each partnering organization have met multiple times to develop and review the specifications for the mental health module that eCW is developing for Piedmont Community Services Board. It is the expectation of the workgroup that the module will encompass all the services provided by a community services board including mental health, mental retardation and substance abuse.

Community Care Network of Virginia has setup the bank of servers (Application Services Provider model) that are necessary to operate the network and software for the project. Piedmont Access to Health Services, the community health center and partner in Danville, has begun the process of setting up and testing their equipment to utilize the eCW software. The equipment includes tablets for the providers which will be used to enter patient visit notes. They will go live on August 27, 2007.

Community Care Network of Virginia has developed patient authorization forms and data sharing protocols to be used by the partners. These materials explain data sharing to the patient and requires a patient signature before information can be exchanged.

CareSpark

CareSpark has proceeded with review of state laws regulating health information exchange in Virginia and Tennessee, assuring the policies and data-sharing agreements are in compliance with state regulations as well as federal laws protecting patient privacy and confidentiality. Data-sharing agreements and business associate agreements are being reviewed by provider organizations, in order to begin populating the regional master patient index in August 2007 and exchange of clinical information in September 2007. Further definition and adoption of policies governing use of health information for the purpose of population health improvement and research are to be completed during fourth quarter of 2007, in conjunction with the timeframe for CareSpark's data repository to be available for use in compiling and analyzing data for public health improvement. These policies will be made available for use by other organizations in the commonwealth.

CareSpark is achieving financial sustainability through the payment of fees by employers and payers for enrollment of covered lives for decision support services. Although this service (provided by ActiveHealth Management to CareSpark) is delivered non-electronically since April 1, 2007 for 22,500 persons enrolled by Eastman Chemical Company, interfaces for exchange of real-time clinical data and messaging will be deployed in fourth quarter of 2007 (by which time CareSpark anticipates 35,000 enrolled members).

Milestones for development of technical infrastructure include the following:

- a. selection of Holston Medical Group's OnePartner to provide data center services beginning in August 2007

- b. enhanced security and protection of privacy through the “Master Patient Option Preference” to prevent unauthorized records from leaving the provider facility to enter the CareSpark network
- c. selection of portal vendor in August 2007, for deployment of physician portal by Oct. 1, 2007
- d. review of options for document repository (to be ready by Oct. 1, 2007) and data repository (to be ready by Dec 2007)

To further expand the network capabilities, CareSpark has submitted two proposals for funding to HHS:

- a. participation with Northrop Grumman for a BioSurveillance / Situational Awareness project with the CDC
- b. participation in NHIN Trial Implementation with involvement from CGI and other partners in the CareSpark Consortium

To prepare for the launch of the system, CareSpark has been doing intensive outreach and communications to physicians and practice managers in the region, providing materials and information regarding options for patient awareness, notification and consent to exchange data through the CareSpark network.

CareSpark was awarded \$2.6 million in their successful NHIN II application. There will also be future funding based on which use cases are awarded to CareSpark. More information is available on the HHS and CareSpark webpages.

MedVirginia

MedVirginia’s original proposal to the Governor’s Health Information Technology Council involved an electronic prescribing initiative with the Virginia Department of Human Resource Management. Although that initiative will be developed, the implementation would be difficult within a limited timeframe. Therefore, a meeting was convened with Secretary Chopra to discuss the award and other opportunities for MedVirginia collaboration. It was decided to focus the grant funds on two areas. The first is supporting the five Richmond area free clinics and their need for clinical and administrative automation. Significant progress has been realized: project scope has been defined; IT assessments have been performed for all clinics; proposals have been prepared for providing IT infrastructure for standardized eligibility screening and referral coordination; and a new pharmacy information system is being implemented at CrossOver’s community pharmacy that will enable connectivity with all free clinics via MedVirginia’s e-prescribing application. This project implementation will be shared with CareSpark to assist them with the Project Access in the far southwest. The second area involves MedVirginia working with the Department of Mental Health Mental Retardation and Substance Abuse Services to assess the feasibility of connecting all the Community Service Boards to the state Community Resource Pharmacy. Preliminary meetings have been held to begin the assessment process and upon completion, a project plan will be constructed.

As with CareSpark, MedVirginia submitted a successful proposal for NHIN II funding. MedVirginia was awarded \$2.5 million and will have access to future funding based on which use cases are awarded. More information is available on the HHS and MedVirginia webpages.

Electronic Master Patient Index

While an electronic master patient index is frequently seen as a necessary pre-condition for quality clinical data exchange there are at least two and possibly more models that a master patient index could follow.

The first and most frequently used by hospitals is to assign each person a unique identifier. This identifier would be a number or alphanumeric assigned to each person by either the state or some other entity. When expanded beyond a hospital or system and out to statewide or nationwide deployment this model poses many of the same security concerns that caused social security numbers to become protected information as well as logistical concerns.

The second model involves “probabilistic matching” and does not require a unique identifier. Instead a complicated algorithm uses information such as name, date of birth, etc. to uniquely identify the John Smith in your hospital waiting room as the same John Smith whose health information you’re trying to retrieve. Similar methods are used today in the financial industry for credit check purposes.

Both of these models require funding well in excess of the amount appropriated by the General Assembly for a pilot project. There also needs to be a consensus in the medical community among payers, providers (both large and small), and the various regional health information networks in Virginia on what the proper model should be.

Due to the limited funding available and the lack of consensus on the appropriate model to test out, Secretaries Chopra and Tavenner felt that it would be inappropriate to spend the resources made available by the General Assembly until there is a more mature environment. With the work of the Health IT Council, the JCOTS subcommittee on Electronic Records, the Health Reform Commission, and the burgeoning Virginia Health Exchange Network sponsored by the Virginia Hospital and Healthcare Association and the Virginia Association of Health Plans we are making strides towards such an environment.

Consequently, none of the \$250,000 appropriated by the General Assembly in item 293 section 2 of Chapter 3 has been expended and it has been recommended that the money be returned to the budget.